FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019364

Facility Name: Central Nursing

Address: 2450 North Central Avenue (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: (773) 889-1333 **Fax #** (773) 889-1516

HFS ID Number: 362801271001

Date of Initial License for Current Owners: 01/01/1973

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford B. Alper - Principal

(Firm Name & Address) Kessler Orlean Silver & Company, P.C.
1101 Lake Cook Road, Ste C, Deerfield, IL 60015-5233

(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 245

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	78,137	1,648	6,303	86,088	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	78,137	1,648	6,303	86,088	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.27%

D. How many bed-hold days during this year were paid by the Department?
2,240 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 3,470

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,636	29,609	15,076	213,321		213,321	38,000	251,321			1
2	Food Purchase		178,294		178,294	(25,853)	152,441	(445)	151,996			2
3	Housekeeping	198,317	7,947		206,264		206,264		206,264			3
4	Laundry		11,104		11,104		11,104		11,104			4
5	Heat and Other Utilities			164,046	164,046		164,046	3,215	167,261			5
6	Maintenance		31,307	14,814	46,121		46,121	29,130	75,251			6
7	Other (specify):*			12,611	12,611		12,611		12,611			7
8	**TOTAL General Services**	366,953	258,261	206,547	831,761	(25,853)	805,908	69,900	875,808			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,617,598	72,428	112,264	1,802,290		1,802,290		1,802,290			10
10a	Therapy			32,026	32,026		32,026		32,026			10a
11	Activities		350	3,981	4,331		4,331		4,331			11
12	Social Services	53,415		3,561	56,976		56,976		56,976			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,671,013	72,778	151,832	1,895,623		1,895,623		1,895,623			16
	C. General Administration											
17	Administrative			451,508	451,508		451,508	(231,769)	219,739			17
18	Directors Fees											18
19	Professional Services			66,003	66,003		66,003		66,003			19
20	Dues, Fees, Subscriptions & Promotions			48,419	48,419		48,419	(17,470)	30,949			20
21	Clerical & General Office Expenses	203,412	9,461	7,816	220,689		220,689	128,268	348,957			21
22	Employee Benefits & Payroll Taxes			420,270	420,270	25,853	446,123	30,173	476,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,130	1,130		1,130		1,130			24
25	Other Admin. Staff Transportation			2,716	2,716		2,716	(757)	1,959			25
26	Insurance-Prop.Liab.Malpractice			194,524	194,524		194,524		194,524			26
27	Other (specify):* **Bad Debts**			9,747	9,747		9,747	(9,156)	591			27
28	**TOTAL General Administration**	203,412	9,461	1,202,133	1,415,006	25,853	1,440,859	(100,711)	1,340,148			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,241,378	340,500	1,560,512	4,142,390		4,142,390	(30,811)	4,111,579			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Nursing #0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,444	24,444		24,444	27,778	52,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					243,903	243,903		243,903			33
34	Rent-Facility & Grounds			1,450,710	1,450,710	(243,903)	1,206,807	(1,206,807)				34
35	Rent-Equipment & Vehicles			2,172	2,172		2,172	676	2,848			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,477,326	1,477,326		1,477,326	(1,178,353)	298,973			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,361	1,105	71,466		71,466		71,466			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):* **Internal Feeding**		1,640		1,640		1,640		1,640			43
44	**TOTAL Special Cost Centers**		72,001	135,243	207,244		207,244		207,244			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,241,378	412,501	3,173,081	5,826,960		5,826,960	(1,209,164)	4,617,796			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,627	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(445)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(800)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,747)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,415)	20		28
29	Other-Attach Schedule	(3,274)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,354)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,206,810)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,206,810)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,209,164)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Central Nursing

ID# **0019364**

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Deductible Dues	$ (3,141)	20	1
2	Franchise Tax	(100)	21	2
3	Franchise Tax - Management	(33)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,274)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	38,000	0	0	0	0	0	0	0	0	38,000	1
2	Food Purchase	(445)	0	0	0	0	0	0	0	0	0	0	(445)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,215	0	0	0	0	0	0	0	0	0	3,215	5
6	Maintenance	0	494	28,636	0	0	0	0	0	0	0	0	29,130	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(445)	3,709	66,636	0	0	0	0	0	0	0	0	69,900	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(451,508)	219,739	0	0	0	0	0	0	0	0	(231,769)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(17,556)	86	0	0	0	0	0	0	0	0	0	(17,470)	20
21	Clerical & General Office Expenses	(433)	1,325	127,376	0	0	0	0	0	0	0	0	128,268	21
22	Employee Benefits & Payroll Taxes	0	30,173	0	0	0	0	0	0	0	0	0	30,173	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(800)	0	43	0	0	0	0	0	0	0	0	(757)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(9,747)	591	0	0	0	0	0	0	0	0	0	(9,156)	27
28	**TOTAL General Administration**	(28,536)	(419,333)	347,158	0	0	0	0	0	0	0	0	(100,711)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,981)	(415,624)	413,794	0	0	0	0	0	0	0	0	(30,811)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Central Nursing **#** 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	26,627	0	1,151	0	0	0	0	0	0	0	0	27,778	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,206,807)	0	0	0	0	0	0	0	0	0	(1,206,807)	34
35	Rent-Equipment & Vehicles	0	676	0	0	0	0	0	0	0	0	0	676	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	26,627	(1,206,131)	1,151	0	0	0	0	0	0	0	0	(1,178,353)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,354)	(1,621,755)	414,945	0	0	0	0	0	0	0	0	(1,209,164)	45

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	50.00%	Balmoral Home, Inc.	Chicago			
		Sovereign Healthcare, LLC	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management fees	$ 451,508	Nivram Management, Inc.	50.00%	$	$ (451,508)	1
2	V		21	Bank Charges		Nivram Management, Inc.	50.00%	29	29	2
3	V		21	Office Expenses		Nivram Management, Inc.	50.00%	1,296	1,296	3
4	V		20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	86	86	4
5	V		27	Franchise Tax		Nivram Management, Inc.	50.00%	33	33	5
6	V		22	Payroll Taxes		Nivram Management, Inc.	50.00%	27,518	27,518	6
7	V		5	Utilities		Nivram Management, Inc.	50.00%	3,215	3,215	7
8	V		27	Insurance		Nivram Management, Inc.	50.00%	558	558	8
9	V		6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	397	397	9
10	V		22	Health Insurance		Nivram Management, Inc.	50.00%	2,655	2,655	10
11	V		6	Scavenger		Nivram Management, Inc.	50.00%	97	97	11
12	V		34	Rent	1,206,807	Henry Mermelstein			(1,206,807)	12
13	V		35	Equipment Rental		Nivram Management, Inc.	50.00%	676	676	13
14	Total				$ 1,658,315			$ 36,560	$ * (1,621,755)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 43	$ 43	15
16	V	21	Postage		Nivram Management, Inc.	50.00%	441	441	16
17	V	30	Depreciation		Nivram Management, Inc.	50.00%	1,151	1,151	17
18	V	21	Data Processing		Nivram Management, Inc.	50.00%	506	506	18
19	V	21	Telephone		Nivram Management, Inc.	50.00%	344	344	19
20	V	6	Plant Salary		Nivram Management, Inc.	50.00%	28,636	28,636	20
21	V	17	Asst. Administrator		Nivram Management, Inc.	50.00%	42,955	42,955	21
22	V	21	Office Manager		Nivram Management, Inc.	50.00%	19,213	19,213	22
23	V	1	Dietary Supervisor		Nivram Management, Inc.	50.00%	38,000	38,000	23
24	V	17	Administrator		Nivram Management, Inc.	50.00%	150,000	150,000	24
25	V	17	Administrator		Nivram Management, Inc.	50.00%	26,784	26,784	25
26	V	21	Administrator		Nivram Management, Inc.	50.00%	35,848	35,848	26
27	V	21	Clerical		Nivram Management, Inc.	50.00%	71,024	71,024	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 414,945	$ * 414,945	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Henry Mermelstein	Administrator	Administrative	None	100,000	48	60.00	Salary	$ 150,000	L 17,Col 8	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	52,000	40	42.22	Salary	38,000	L 1,Col 8	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	79,364	5	26.52	Salary	28,636	L 6,Col 8	3
4	Doreen Mermelstein	Office Manager	Administrative	None	84,133	7	18.70	Salary	19,213	L 21,Col 8	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	119,045	7	26.51	Salary	42,955	L 17,Col 8	6
7	Joseph Mermelstein	Owner	Administrative	50.00	68,216	3	28.19	Salary	26,784	L 17,Col 8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 305,588		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Bank Charges	Resident Beds	924	5	$ 110	$	245	$ 29	1
2		Office Expenses	Resident Beds	924	5	4,887		245	1,296	2
3		Dues & Subscriptions	Resident Beds	924	5	325		245	86	3
4		Franchise Tax	Resident Beds	924	5	125		245	33	4
5		Payroll Taxes	Resident Beds	924	5	103,783		245	27,518	5
6		Utilities	Resident Beds	924	5	12,124		245	3,215	6
7		Insurance	Resident Beds	924	5	2,106		245	558	7
8		Repairs & Maintenance	Resident Beds	924	5	1,497		245	397	8
9		Health Insurance	Resident Beds	924	5	10,013		245	2,655	9
10		Scavenger	Resident Beds	924	5	367		245	97	10
11		Equipment Rental	Resident Beds	924	5	2,549		245	676	11
12		Auto Expense	Resident Beds	924	5	163		245	43	12
13		Postage	Resident Beds	924	5	1,662		245	441	13
14		Depreciation	Resident Beds	924	5	4,342		245	1,151	14
15		Data Processing	Resident Beds	924	5	1,909		245	506	15
16		Telephone	Resident Beds	924	5	1,299		245	344	16
17		Plant Salary	Direct Cost	1	1	28,636	28,636	1	28,636	17
18		Asst. Administrator	Direct Cost	1	1	42,955	42,955	1	42,955	18
19		Office Manager	Direct Cost	1	1	19,213	19,213	1	19,213	19
20		Dietary Supervisor	Direct Cost	1	1	38,000	38,000	1	38,000	20
21		Administrative	Direct Cost	1	1	212,632	212,632	1	212,632	21
22		Clerical	Direct Cost	1	1	71,024	71,024	1	71,024	22
23										23
24										24
25	TOTALS					$ 559,721	$ 412,460		$ 451,505	25

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	209,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	243,903	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,303	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	209,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	243,903	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	198,472	8
2001	203,521	9
2002	205,803	10
2003	238,603	11
2004	243,903	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	2450 N. Central Avenue	$ 13,554.69	$ 13,554.69
2.	13-29-431-014-0000	2450 N. Central Avenue	$ 33,496.20	$ 33,496.20
3.	13-29-431-015-0000	2450 N. Central Avenue	$ 33,547.13	$ 33,547.13
4.	13-29-431-016-0000	2450 N. Central Avenue	$ 33,547.13	$ 33,547.13
5.	13-29-431-017-0001	2450 N. Central Avenue	$ 33,506.69	$ 33,506.69
6.	13-29-431-018-0002	2450 N. Central Avenue	$ 33,426.62	$ 33,426.62
7.	13-29-431-019-0003	2450 N. Central Avenue	$ 33,310.63	$ 33,310.63
8.	13-29-431-020-0004	2450 N. Central Avenue	$ 26,558.25	$ 26,558.25
9.	13-29-431-021-0005	2450 N. Central Avenue	$ 1,435.55	$ 1,435.55
10.	13-29-431-022-0006	2450 N. Central Avenue	$ 1,520.51	$ 1,520.51
		TOTALS	$ 243,903.40	$ 243,903.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	30,000	1973	$ 158,977	1
2					2
3	TOTALS	30,000		$ 158,977	3

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1973	1973	$ 1,729,156	$	30	$	$	$ 1,729,156	4
5					(95,563)						5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1976	8,246		20			8,246	9
10	Hot Water Heater			1983	2,156		10			2,156	10
11	Light Fixtures			1984	14,684		10			14,684	11
12	Roof			1984	20,000		20			19,417	12
13	Heating & Air Conditioning			1983	2,924		20			2,871	13
14	Painting & Decorating			1983	7,863		8			7,863	14
15	Doorways			1986	1,840		15			1,840	15
16	Elevator Upgrade			1986	1,080	63	20	54	(9)	1,023	16
17	Wall Corner Guard			1987	1,531		10			1,531	17
18	Resurface Parking Lot			1987	6,900		15			6,900	18
19	Additions			1988	1,200	38	20	60	22	964	19
20	Heater Foundation			1989	1,000	32	20	50	18	753	20
21	Roof			1990	7,916	251	20	396	145	5,735	21
22	Roof			1990	2,199		8			2,199	22
23	Various Improvements			1990	1,850		8			1,850	23
24	Cublicle Curtains			1992	11,273		10			11,273	24
25	HVAC Improvements			1993	8,907		10			8,907	25
26	Draperies			1993	2,700		10			2,700	26
27	Tiling			1995	6,600	169	10	660	491	6,059	27
28	Leasehold Improvements			1995	15,914		10	1,591	1,591	15,380	28
29	Generator			1996	17,527	450	10	1,753	1,303	14,338	29
30	Roof			1996	4,800	123	10	480	357	3,926	30
31	Doorways			1997	2,465	63	10	247	184	1,773	31
32	Wiring for Emergency System			1997	5,000	128	10	500	372	3,590	32
33	Phone System			1997	8,238		10	824	824	5,751	33
34	Architecture			1998	6,000	153	10	600	447	3,707	34
35	Boiler, A/C, Ductwork			1998	16,664	357	10	1,666	1,309	10,225	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roofing	1998	$ 54,000	$ 1,385	10	$ 5,400	$ 4,015	$ 33,370	37
38	Parking Lot Improvements	1998	8,000	800	10	800		5,333	38
39	Elevator Improvements	1998	4,450	68	10	445	377	2,213	39
40	HVAC Improvemeents	1998	2,820	72	10	282	210	1,460	40
41	Fire Alarm System Doors	1999	107,500	2,756	10	10,750	7,994	55,679	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	1,554	42
43	Elevator Improvements	1999	2,650	68	10	265	197	1,377	43
44	HVAC Improvemeents	1999	20,388	522	10	2,039	1,517	10,555	44
45	Landscape Work	1999	4,100	105	10	410	305	2,123	45
46	Elevator Improvements	2000	89,750	2,301	10	8,975	6,674	37,511	46
47	HVAC Improvemeents	2000	23,639	606	10	2,364	1,758	9,880	47
48	Telephone System	2000	7,500	192	10	750	558	3,134	48
49	Air Conditioning System	2001	4,000	104	10	400	296	1,408	49
50	Air Conditioning System	2001	10,800	277	10	1,080	803	2,849	50
51	Air Conditioning System	2001	2,500	65	10	250	185	505	51
52	Air Conditioning System	2003	5,800	74	10	580	506	3,076	52
53	Door	2004	1,742	44	10	87	43	48	53
54	Nurse Call System	2005	11,000	235	10	550	315	235	54
55	Dual Patient Stations	2005	1,485	32	10	74	42	32	55
56	Wiring-Elevator Recall Relays	2005	480	2	10	24	22	2	56
57	Air Cleaning Equipment	2005	2,936	38	10	147	109	38	57
58	Condenser	2005	1,780	23	10	89	66	23	58
59	Fan Coil Unit	2005	2,832	12	10	141	129	12	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,194,222	$ 11,685		$ 45,083	$ 33,398	$ 2,067,234	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 57,034	$ 5,530	$ 5,703	$ 173		$ 46,228	71
72	Current Year Purchases	7,229	7,229	723	(6,506)		7,229	72
73	Fully Depreciated Assets	400,016					400,016	73
74	Nivram Management Depr		1,151	713	(438)			74
75	TOTALS	$ 464,279	$ 13,910	$ 7,139	$ (6,771)		$ 453,473	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Storage	Storage Trailer	1986	$ 900	$	$	$	10	$ 900	76
77	Administrative	1999 Oldsmobile	1999	22,218				6	22,218	77
78										78
79										79
80	TOTALS			$ 23,118	$	$	$		$ 23,118	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,840,596	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,595	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,222	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,627	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,543,825	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 2,172 Description: Ice Makers $900; Copy machine $1,272
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care	39-3	17	visits	1,105				17	1,105	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-2		# of prescrpts				7,088		7,088	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Rentals	39-2						63,273		63,273	13
	Other (specify): Internal Tube Feeding	43-2						1,640		1,640	
14	TOTAL				$ 1,105		$	$ 72,001	17	$ 73,106	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,277,637	$ 1,277,637	1
2	Cash-Patient Deposits	58,792	58,792	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	855,839	855,839	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,116	94,116	6
7	Other Prepaid Expenses	510	510	7
8	Accounts Receivable (owners or related parties)	1,846,102	1,846,102	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,132,996	$ 4,132,996	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	474,848	533,978	15
16	Equipment, at Historical Cost	336,645	530,429	16
17	Accumulated Depreciation (book methods)	(433,723)	(2,269,132)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500,100	500,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 877,870	$ 1,183,508	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,010,866	$ 5,316,504	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,773	$ 54,773	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,028	60,028	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,345	140,345	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	209,600	209,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	60,909	60,909	35
	Other Current Liabilities(specify):			
36	Accrued Rent and Others	1,114,257	1,114,257	36
37	Due to IDPA	146,573	146,573	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,786,485	$ 1,786,485	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,786,485	$ 1,786,485	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,224,381	$ 3,530,019	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,010,866	$ 5,316,504	48

***(See instructions.)**

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,119,339	1
2	Restatements (describe):		2
3	**Rounding**	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,119,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,025,038	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,920,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 105,038	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,224,381	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,654,005	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,654,005	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,526	6
7	Oxygen	91,141	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 104,667	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,837	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,837	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,164	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,164	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	15,845	28
28a	Write Off Old Outstanding Checks	45,837	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,682	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,913,355	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,761	31
32	Health Care	1,895,623	32
33	General Administration	1,415,006	33
	B. Capital Expense		
34	Ownership	1,477,326	34
	C. Ancillary Expense		
35	Special Cost Centers	73,106	35
36	Provider Participation Fee	134,138	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,826,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,086,395	41
42	**Income Taxes**	(61,357)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,025,038	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,132	2,408	$ 84,408	$ 35.05	1
2	Assistant Director of Nursing	1,904	2,144	50,384	23.50	2
3	Registered Nurses	34,555	36,773	814,915	22.16	3
4	Licensed Practical Nurses	6,037	6,531	107,826	16.51	4
5	CNAs & Orderlies	58,488	63,304	560,065	8.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,261	6,477	53,415	8.25	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,069	2,229	23,154	10.39	13
14	Head Cook	3,170	3,434	42,948	12.51	14
15	Cook Helpers/Assistants	12,689	13,864	102,534	7.40	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	18,406	20,181	198,317	9.83	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,594	12,262	203,412	16.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,305	169,607	$ 2,241,378 *	$ 13.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 15,076	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	950	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	425	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant		30,676	10a-3	42
43	Speech Therapy Consultant	F	925	10a-3	43
44	Activity Consultant	E	3,981	11-3	44
45	Social Service Consultant	E	3,561	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 55,594		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,567	$ 111,314	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,567	$ 111,314		53

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Service	$ 2,378
Accu-Med Services, Inc.	Computer Support	2,640
Emdeon Business Services	Public Aid Consultant	961
Health Data Systems, Inc.	Computer Support	3,282
Kessler Orlean Silver	Accounting	20,700
Myers, Miller & Krauskoff	Legal fees	381
Neal Gerber & Eisenberg	Legal fees	21,248
Richard Peelo	Healthcare Consultant	4,550
Systematic Mngmt Systems	Billing Consultant	5,740
Personnel Planners, Inc.	Unemploymt Consultant	4,123
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 66,003

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,420
Unemployment Compensation Insurance	21,869
FICA Taxes	169,967
Employee Health Insurance	133,388
Employee Meals	25,853
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	17,698
Profit Sharing Contribution	20,000
Chicago Head Tax	5,328
Other Employee Benefits	4,600
Allocation from Management	30,173
TOTAL (agree to Schedule V, line 22, col.8)	$ 476,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,034
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising: Yellow Pages	14,415
IL Council on Long-Term Care	13,267
Less: Non Deductible Dues	(3,141)
Schedule attached	7,713
Allocation from Management	86
Illinois Dept of Public Health	1,990
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(14,415)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,949

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,130
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,130

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long-Term Care $13,267**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,853** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.